Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FREDERICK L MERIAN, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

COSTCO WHOLESALE CORP

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2635-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $265.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier paid for these services IAW the Texas Labor Code and DWC Rules."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2011	99456-W5-WP	$265.00	$265.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 22, 2011
   - 80 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF

   Explanation of benefits dated March 22, 2011
   - 664 - Description not Available

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The Division ordered a DD exam to be performed per Texas Labor Code §408.0041 which states in (h)(1):

   "(h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f)."

   and the Texas Labor Code §408.0041 states in part (a)(1)(2):
   "(a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (1) the impairment caused by the compensable injury;
   (2) the attainment of maximum medical improvement;"

   The requestor billed the amount of $650.00 for CPT code 99456-WP-W5 for DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI and performed an IR examination for one body area. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Documentation supports the 1st musculoskeletal rating of the left knee (lower extremity) Range of Motion (ROM) IR method for $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Also, per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(b). The combined MMI/IR MAR is $650.00.
2. Respondent previously reimbursed $385.00 for CPT code 99456-WP-W5, therefore $265.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $265.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $265.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.